

3490602628  
Born 1/13/1983

5/25/2006

12:24:04 PM Reyes, Jason  
Male Race: Hispanic

Rate 101  
PR 148  
QRS 87  
QT 344  
QTc 446

SINUS TACHICARDIA  
REPOL ABNRM, PROBABLE ISCHEMIA, DIFFUSE

ST dep, T neg, ant/lat/inf

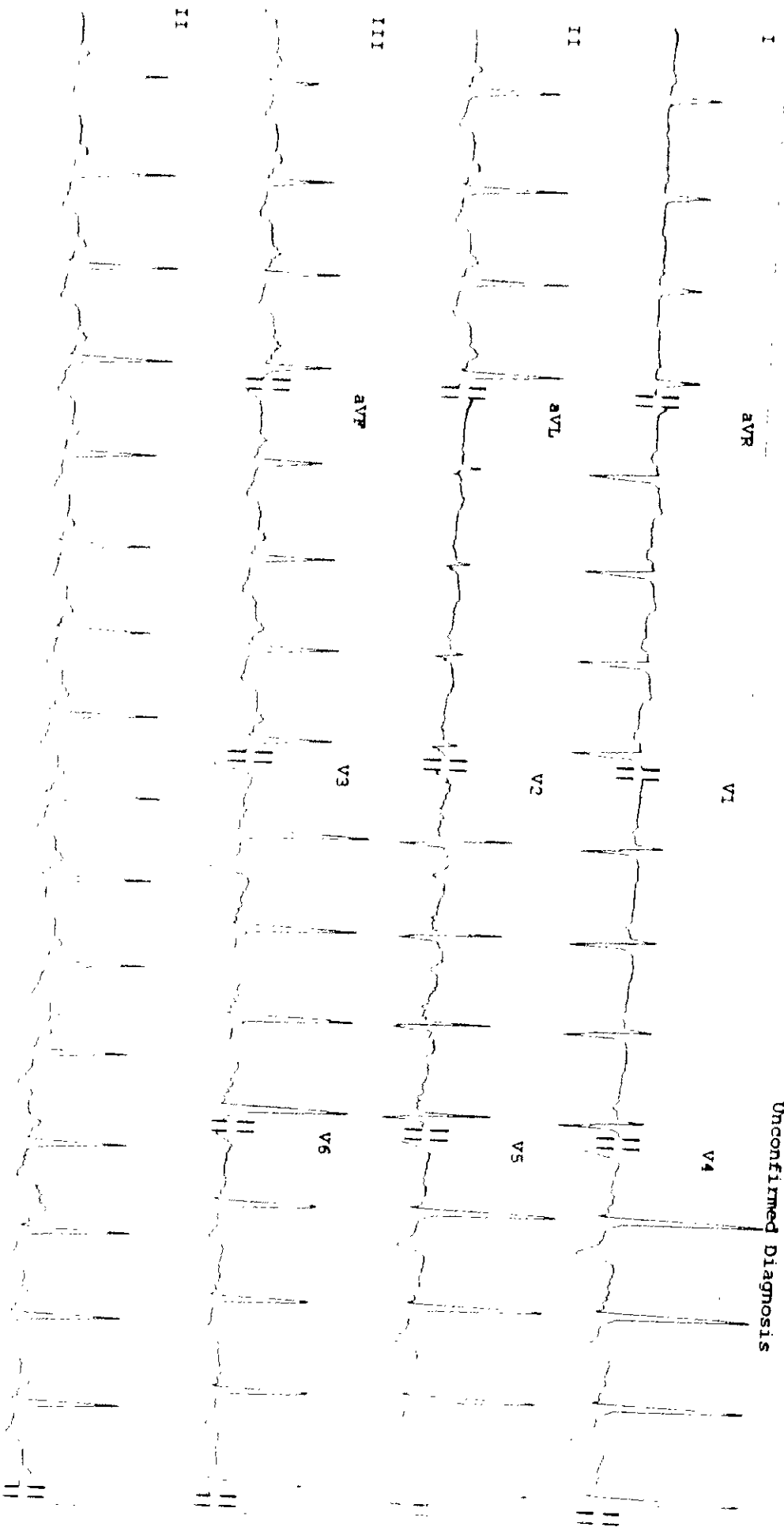
BP: 134/76-16-62-99, PHS

--AXIS--  
P 75  
QRS 60  
T 263

- ABNORMAL ECG -

Fac: LOANER

Unconfirmed Diagnosis



Dev: 12009572

Speed: 25 mm/sec

Limb: 10 mm/mV

Chest: 10 mm/mV

60~0.15-150 Hz

NYC 0000090

PH0909

# CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH  
AND MENTAL HYGIENE

Leave blank for hospital use

Patients' Name \_\_\_\_\_ DOB \_\_\_\_\_

FROM \_\_\_\_\_  
Correctional institution Inmate no. \_\_\_\_\_

Referred to \_\_\_\_\_ Ward / Clinic

Hospital \_\_\_\_\_ / Clinic no. \_\_\_\_\_

Chief complaint or findings:

**Diagnosis, treatment and medications by C.H.S.:**

Other pertinent physical, psychiatric, and historical findings,  
including lab values and x-ray findings:

Request:

Date \_\_\_\_\_ Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_ Approved \_\_\_\_\_

Consultation, findings and recommendations:

ate \_\_\_\_\_ Physician \_\_\_\_\_

*Reminder: Fully Complete the Problem List*

NYC 0000091

# CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH  
AND MENTAL HYGIENE

Leave blank for hospital use

Patients' Name \_\_\_\_\_ DOB \_\_\_\_\_

FROM \_\_\_\_\_  
Correctional institution Inmate no.

Referred to \_\_\_\_\_ Ward / Clinic

Hospital \_\_\_\_\_ / Clinic no.

Chief complaint or findings:

**Diagnosis, treatment and medications by C.H.S.:**

Other pertinent physical, psychiatric, and historical findings,  
including lab values and x-ray findings:

Request:

Thomas Schwane PA

Date \_\_\_\_\_ Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_ Approved \_\_\_\_\_

Consultation, findings and recommendations:

Date \_\_\_\_\_ Physician \_\_\_\_\_



# Neuroscience Associates of New York

1092 Farago Street, Staten Island, NY 10304 • 718/448-3210 • Fax: 718/815-3579

## Neurology

Stephen A. Kulick, M.D., F.A.A.N., F.A.C.P.  
Steven B. Schwartzberg, M.D.  
Audrey L. Halpern, M.D.

## Pain Management

Germaine N. Rowe, M.D., F.A.A.P.M.P.  
Glenn D. Babus, D.O.

## Neurological Surgery

Edwin M. Chang, M.D., F.A.C.S.  
John S. Shlau, M.D., F.A.C.S.  
Anthony J.G. Akintu, M.D.

## Emeritus

Harvey R. Leventhal, M.D., F.A.C.S.

## Neuropsychology

Reuben L. Weiss, Ph.D.

May 1, 2006

Re: Jayson Reyes

To Whom It May Concern:

Mr. Reyes has been followed in our pain management practice since June 2003. He suffers from chronic left lower extremity pain secondary to RSD or reflex sympathetic dystrophy, which causes him to have a permanent disability. The patient has not been seen in our office in the last few months. Previously the patient had been managed on a regimen of medications including OxyContin 20 mg. q 6h.

If you have any further questions please feel free to contact our office at 718-448-3210 extension 2287.

Sincerely yours,

*G. Rowe M.D.*

Naomi Alcock, P.A.  
Germaine N. Rowe, M.D.

NA/km

Video ID: 16675411/Text ID: 11363963



1099 Targee Street, Staten Island, NY 10304 • Phone: (718) 448-3210 • Fax: (718) 442-9085

**FAX TRANSMISSION**

DATE: 5/1/00

TO: Casaria

COMPANY: \_\_\_\_\_

FAX: 398-8495

RE: Raymond / King

Number of pages including cover: 22

**MESSAGE:**

FROM: Y Yabme

DEPT: Public Works

FAX: 718-447-7192  
TEL: 718-448-3210 X 2285

NEUROLOGY  
Stephen A. Kuzek, MD, FAHA, FACP  
Anthony L. Holzman, MD

PEDIATRIC NEUROLOGY  
Steven E. Schwartzberg, MD  
Laurie M. Vignos, MD

NEUROSURGERY  
Edwin M. Cheng, MD, FACS  
John S. Shores, MD  
Anthony L.G. Martin, MD  
Arvey R. Loventhal MD, FACS  
Eunice

**ORTHOPAEDICS**  
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Joseph A. Samra, MD, FACS  
Albert R. Accardo, Jr, MD  
John P. Smith, MD  
David A. Granger, MD  
Joseph J. Giannazzo, MD, FACS  
Deborah A. Rinaldy, MD  
Nancy Pincus, MD

**NEUROBIOLOGY**  
Richard S. Purdy, MD, FACP  
Aimee E. George, MD, FACP

PRIN MANAGERINT  
Germains R. Pong, MR. FLATAG  
Steph. P. Lohy, OO

PHYSICAL THERAPY  
Alejandro E. Mariano, PT  
Luisa Orrego, PT

NEUROPSYCHOLOGY  
Lecture Notes, PhD

NY Prescription Form 13-00001 (Rev. 12/2008)

**OFFICIAL NEW YORK STATE PRESCRIPTION**

**HEALTHCARE ASSOCIATES IN MEDICINE P.C.**

☒ GERMAINE N ROWE MD  
LIC. 204300

☒ NAOMI BALCOCK PA  
LIC. 007057

☐ GLENN D BARUS DO  
LIC. 229217

☐ SABRINA R SIMONETTI PA  
LIC. 010110

1036 TARGEE STREET, STATEN ISLAND, NY 10304 (718) 448-3210

PHARMACY USE ONLY

Patient Name Jayson Reyes Date 5/1/06

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Age \_\_\_\_\_ Sex M/F

Re PT 2 - 3x/wk X 6-8wks  
+ 1x/week  
multispecialty  
Dr. Reflex Sympathetic  
Dystrophy (Duchenne)

Prescriber Signature [Signature] Alonso P

THIS PRESCRIPTION WILL BE FILLED GENERALLY UNLESS PATRONER WRITES "DO NOT FILL CITY"

APRIL 11 2006

818081 12

PHARMACY USE ONLY

TEST AREA

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## NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CHS FORM

## MEDICATION ORDER SHEET

USE BALL POINT PEN AND PRESS FIRMLY

PATIENT LAST NAME <b>REYES</b>		FIRST NAME <b>JASON</b>		BOOK & CASE NUMBER <b>3490602628</b>		HOUSING AREA <b>NIC</b>		ALLERGIES	
DRUG <b>OXYCONTIN</b>		DOSE <b>20mg</b>		ROUTE <b>PO</b>		FREQUENCY <b>BID</b>		DURATION <b>7d</b>	
INDICATION <b>PER BH. PAIN MGR</b>									
DRUG <b>CYMBALTA</b>		DOSE <b>60mg</b>		ROUTE <b>PO</b>		FREQUENCY <b>QD</b>		DURATION <b>7d</b>	
INDICATION <b>PER BH. PAIN MGR</b>									
DRUG <b>PRIVIGIL</b>		DOSE <b>200mg</b>		ROUTE <b>PO</b>		FREQUENCY <b>QAM</b>		DURATION <b>7d</b>	
INDICATION <b>PER BH. PAIN MGR</b>									
DATE <b>3/11/06</b>	TIME	PRESCRIBER SIGNATURE <b>T/S (M)</b>		STAMP <b>0564</b>		Thomas Schwaner, PA		PHYSICIAN <b>H. Bhatti, MD</b>	
PATIENT LAST NAME <b>REYES</b>		FIRST NAME <b>JASON</b>		BOOK & CASE NUMBER <b>3490602628</b>		HOUSING AREA <b>NIC</b>		ALLERGIES	
DRUG <b>TYLENOL</b>		DOSE <b>650mg</b>		ROUTE <b>PO</b>		FREQUENCY <b>BID</b>		DURATION <b>4d</b>	
INDICATION									
DRUG		DOSE		ROUTE		FREQUENCY		DURATION	
INDICATION									
DRUG		DOSE		ROUTE		FREQUENCY		DURATION	
INDICATION									
DATE <b>3/9/06</b>	TIME	PRESCRIBER SIGNATURE <b>T/S (M)</b>		STAMP <b>0564</b>		Thomas Schwaner, PA		PHYSICIAN <b>H. Bhatti, MD</b>	
PATIENT LAST NAME <b>REYES</b>		FIRST NAME <b>JASON</b>		BOOK & CASE NUMBER <b>3490602628</b>		HOUSING AREA <b>NIC</b>		ALLERGIES	
DRUG <b>OXYCONTIN</b>		DOSE <b>20mg</b>		ROUTE <b>PO</b>		FREQUENCY <b>BID</b>		DURATION <b>7d</b>	
INDICATION <b>PER BH. PAIN MGR</b>									
DRUG <b>CYMBALTA</b>		DOSE <b>60mg</b>		ROUTE <b>PO</b>		FREQUENCY <b>QD</b>		DURATION <b>7d</b>	
INDICATION									
DRUG <b>PRIVIGIL</b>		DOSE <b>200mg</b>		ROUTE <b>PO</b>		FREQUENCY <b>QAM</b>		DURATION <b>7d</b>	
INDICATION <b>PER BH. PAIN MGR</b>									
DATE <b>5/3/06</b>	TIME	PRESCRIBER SIGNATURE <b>T/S (M)</b>		STAMP <b>0564</b>		Thomas Schwaner, PA		PHYSICIAN <b>H. Bhatti, MD</b>	

Write medication orders beginning from bottom of page.  
Chart Copy-White; Pharmacy Copy-Yellow

NYC 0000096

**CONSULTATION REQUEST**NEW YORK CITY DEPARTMENT OF HEALTH  
AND MENTAL HYGIENE

Leave blank for hospital use

Patients' Name REYES, JASON DOB 1/13/82  
 FROM NIC 03 / 349 0602628  
 Correctional institution Inmate no.  
 Referred to PT Ward / Clinic  
 Hospital / Clinic no.

PT

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

23 YOM Hx of

RSD REFLEX SYMPATHETIC DYSTROPHY  
SINCE SEPT 2002

BILATERAL LEG PAIN + WEAKNESS

HYPERAESTHESIA TO (L) HEEL

Other pertinent physical, psychiatric, and historical findings,  
including lab values and x-ray findings:

Request: PT FOR ROM TO  
 LOWER EXTREMITIES (AS TOLERATED)

Date 5/4/06 Referring Physician Thomas Schwane, MD

Phone

Harinder Bhatti, MD  
Approved

Consultation, findings and recommendations:

NYC 0000097

PT has report of RSD; 2° to work related injury;  
 S/S of RSD to @ foot m/l and plantar surface  
 ± ↓ ROM @ ankle complex evident; pt has hyperreflexia  
 in @ CA ± cogwheel oscillations evident when transferring  
 w. B. or walking; gait is impaired by RSD ± 7 (8/10)  
 pain levels brought on with w.B.; 7 to ↓ pain  
 syndrome physical agents (U.S. Dept) return to P.T.



NEW YORK CITY DEPARTMENT OF HEALTH  
AND MENTAL HYGIENEMEDICATION  
ADMINISTRATION RECORDPATIENT'S NAME: Royes, JasonID #: 349-06202628DIAGNOSIS: Reflex Sympathetic dystALLERGY: Fentanyl LOC: D 2A

PATIENT LAST NAME <u>Royes</u>		FIRST NAME <u>Jason</u>	
ID # <u>3490602628</u>		LOCATION <u>Nic D2A</u>	
DRUG <u>Oxycontin SR</u>		NEW	
INDICATION <u>Pain</u>			
DOSE <u>10</u>	ROUTE <u>PO</u>	RENEW	
FREQUENCY <u>Q12hs</u>	DURATION <u>2 day then taper</u>	CHANGE	
DATE <u>4/18/06</u>	TIME <u>6:00</u>	NURSE <u>Habib Kamkhaji, MD</u>	
MO/PA SIGNATURE <u>[Signature]</u>	TIME <u>0730</u>	RPH	
O/C DATE	NURSE	TIME	RPH

MONTH		YEAR	
APRIL		2006	
D	HR	18	19
9A	0	D/C	4/19/06
9P	0		
D	HR		

PATIENT LAST NAME <u>Royes</u>		FIRST NAME <u>Jason</u>	
ID # <u>3490602628</u>		LOCATION <u>Nic D2A</u>	
DRUG <u>Neurontin</u>		NEW	
INDICATION			
DOSE <u>300</u>	ROUTE <u>PO</u>	RENEW	
FREQUENCY <u>TID</u>	DURATION <u>2 WKS</u>	CHANGE	
DATE <u>4/18/06</u>	TIME <u>6:00</u>	NURSE <u>Habib Kamkhaji, MD</u>	
MO/PA SIGNATURE <u>[Signature]</u>	TIME <u>0730</u>	RPH	
O/C DATE	NURSE	TIME	RPH

MONTH		YEAR	
APRIL		2006	
D	HR	18	19
5A	X	20	21
1P	1	22	23
9P	1	24	25
D	HR	26	27

PATIENT LAST NAME <u>Royes</u>		FIRST NAME <u>Jason</u>	
ID # <u>3490602628</u>		LOCATION <u>Nic D2A</u>	
DRUG <u>Lidoderm patch 5%</u>		NEW	
INDICATION			
DOSE <u>1 Patch</u>	ROUTE <u>Topical</u>	RENEW	
FREQUENCY <u>BID PM</u>	DURATION <u>2 WKS</u>	CHANGE	
DATE <u>4/18/06</u>	TIME <u>0730</u>	NURSE <u>Habib Kamkhaji, MD</u>	
MO/PA SIGNATURE <u>[Signature]</u>	TIME <u>0730</u>	RPH	
O/C DATE	NURSE	TIME	RPH

MONTH		YEAR	
APRIL / May		2006	
D	HR	18	19
9A	1	20	21
9P	1	22	23
D	HR	24	25

1. Refusal
2. Out of Court
3. Out of Hospital/specialty clinic
4. Off Unit (i.e. visit, recreation, library)

5. Withheld (pending lab, abnormal lab, and/or vital signs)
6. Non-formulary and not available at time of administration
7. Not in cassette, pharmacy notified
8. Medication given to take to court or hospital specialty clinic
9. OOS (Out of Stock) at time of administration



## STAT OR SINGLE DOSE MEDICATIONS

[illegible]

**MEDICATIONS NOT ADMINISTERED**

[illegible]

**NURSE'S SIGNATURE**

[illegible]

## STAT OR SINGLE DOSE MEDICATIONS

[illegible]

**MEDICATIONS NOT ADMINISTERED**

[illegible]

**NURSE'S SIGNATURE**

DATE	FULL SIGNATURE	INITIALS	PRINT NAME
4/18/06	Richardson	LR	LR, RICHARDSON
4/19/06	W	W	Winsome Douglas-Hewitt, LPN
4/21	Williams	EW	
4/22	T. E. J. H.	T. E.	T. E. J. H.
4/23/06	W	W	F. J. H.
4/25	W	W	W. J. H.



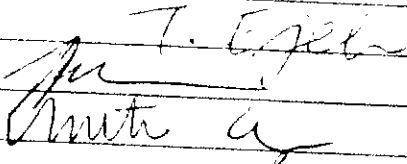
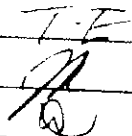
**STAT OR SINGLE DOSE MEDICATIONS**

[illegible]

**MEDICATIONS NOT ADMINISTERED**

[illegible]

**NURSE'S SIGNATURE**

NURSE'S SIGNATURE			
DATE	FULL SIGNATURE	INITIALS	PRINT NAME
4/19/06			Wincik, Wladyslaw, LPN
4/21 4/24/06 4/25			T. E. J. H. For Thomas USANTB CRT 20

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CHS FORM B

## MEDICATION ORDER SHEET

USE BALL POINT PEN AND PRESS FIRMLY

PATIENT LAST NAME REYES		FIRST NAME JASON		BOOK & CASE NUMBER 349 06 02 628		HOUSING AREA D3		ALLERGIES NKA	
DRUG NORCOPTIN		DOSE 800		ROUTE PO		FREQUENCY TID		DURATION 14Q	
INDICATION									
3									
DRUG COLACE		DOSE 200mg		ROUTE PO		FREQUENCY QD		DURATION 30Q	
INDICATION									
DRUG P LINDICANE (MTC)		DOSE 10		ROUTE TOPICAL		FREQUENCY QD		DURATION 14Q	
INDICATION									
DATE 5/2/06		TIME		PRESCRIBER SIGNATURE [Signature]		STAMP Harjinder Bhatti, MD Thomas Schwane, PA		RPH	
PATIENT LAST NAME REYES		FIRST NAME JASON		BOOK & CASE NUMBER 349 06 02 628		HOUSING AREA D3		ALLERGIES NKA	
DRUG OXYCONTIN SR		DOSE 20mg		ROUTE PO		FREQUENCY BID		DURATION 7Q	
INDICATION									
2									
DRUG CAMPALTA		DOSE 60mg		ROUTE PO		FREQUENCY QD		DURATION 7Q	
INDICATION									
DRUG PROVIGIL		DOSE 200mg		ROUTE PO		FREQUENCY Q AM		DURATION 7Q	
INDICATION									
DATE 5/2/06		TIME		PRESCRIBER SIGNATURE [Signature]		STAMP Harjinder Bhatti, MD Thomas Schwane, PA		RPH	
PATIENT LAST NAME REYES		FIRST NAME JASON		BOOK & CASE NUMBER 349 06 02 628		HOUSING AREA D3		ALLERGIES NKA	
DRUG OXYCONTIN SR		DOSE 20mg		ROUTE PO		FREQUENCY BID		DURATION 7Q	
INDICATION									
1									
PER PAIN MGR ABUSE.									
DRUG CAMPALTA		DOSE 60mg		ROUTE PO		FREQUENCY QD		DURATION 7Q	
INDICATION									
PER PAIN MGR									
DRUG PROVIGIL		DOSE 200mg		ROUTE PO		FREQUENCY Q AM		DURATION 7Q	
INDICATION									
PER PAIN MGR Harjinder Bhatti, MD									
DATE 4/27/06		TIME		PRESCRIBER SIGNATURE [Signature]		STAMP Thomas Schwane, PA		RPH	

Write medication orders beginning from bottom of page  
Chart Copy-White; Pharmacy Copy-Yellow

## NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CHS FORM

## MEDICATION ORDER SHEET

USE BALL POINT PEN AND PRESS FIRMLY

PATIENT LAST NAME <b>REYES</b>		FIRST NAME <b>JASON</b>		BOOK & CASE NUMBER <b>3490602628</b>		HOUSING AREA <b>NIC 03</b>		ALLERGIES <b>NKA</b>	
DRUG <b>4C 1L CREAM</b>		DOSE <b>PF</b>		ROUTE <b>TOPICAL</b>		FREQUENCY <b>BID</b>		DURATION <b>14d</b>	
INDICATION									
3									
DRUG		DOSE		ROUTE		FREQUENCY		DURATION	
INDICATION									
DRUG		DOSE		ROUTE		FREQUENCY		DURATION	
INDICATION									
DATE <b>4/26/06</b>	TIME	PRESCRIBER SIGNATURE <b>[Signature]</b>		STAMP <b>PA Harijinder Bhatti, MD</b>		NPH			
PATIENT LAST NAME <b>REYES</b>		FIRST NAME <b>JASON</b>		BOOK & CASE NUMBER <b>3490602628</b>		HOUSING AREA <b>NIC 03</b>		ALLERGIES <b>NKA</b>	
DRUG <b>NEURONTIN</b>		DOSE <b>300mg</b>		ROUTE <b>PO</b>		FREQUENCY <b>TID</b>		DURATION <b>14d</b>	
INDICATION <b>PER PAIN MGN (BELLERUMF)</b>									
DRUG		DOSE		ROUTE		FREQUENCY		DURATION	
INDICATION									
DRUG		DOSE		ROUTE		FREQUENCY		DURATION	
INDICATION									
DATE <b>4/26/06</b>	TIME	PRESCRIBER SIGNATURE <b>[Signature]</b>		STAMP <b>PA Thomas Schwabner, PA</b>		NPH			
PATIENT LAST NAME <b>REYES</b>		FIRST NAME <b>JASON</b>		BOOK & CASE NUMBER <b>3490602628</b>		HOUSING AREA <b>NIC 03</b>		ALLERGIES <b>NKA</b>	
DRUG <b>OXYCONTIN SR</b>		DOSE <b>20mg</b>		ROUTE <b>PO</b>		FREQUENCY <b>BID</b>		DURATION <b>7d</b>	
INDICATION <b>PER PAIN MGN (BELLERUMF)</b>									
DRUG		DOSE		ROUTE		FREQUENCY		DURATION	
INDICATION									
DRUG <b>CYMBALTA</b>		DOSE <b>60mg</b>		ROUTE <b>PO</b>		FREQUENCY <b>QD</b>		DURATION <b>7d</b>	
INDICATION <b>PER PAIN MGN (BELLERUMF)</b>									
DRUG		DOSE		ROUTE		FREQUENCY		DURATION	
INDICATION									
DRUG <b>PROVIGIL</b>		DOSE <b>250mg</b>		ROUTE <b>PO</b>		FREQUENCY <b>QAM</b>		DURATION <b>7d</b>	
INDICATION <b>PER PAIN MGN (BELLERUMF)</b>									
DATE <b>4/26/06</b>	TIME	PRESCRIBER SIGNATURE <b>[Signature]</b>		STAMP <b>PA Thomas Schwabner, PA</b>		NPH			

Write medication orders beginning from bottom of page  
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NYC 000105

NEW YORK CITY DEPARTMENT OF HEALTH  
AND MENTAL HYGIENE

CHS FORM A

## MEDICATION ORDER SHEET

USE BALL POINT PEN AND PRESS FIRMLY

ALLERGIES \_\_\_\_\_

4

PATIENT LAST NAME		FIRST NAME	
ID #		LOCATION	
DRUG		NEW	
INDICATION			
DOSE	ROUTE	RENEW	
FREQUENCY	DURATION	CHANGE	
DATE	TIME		
MD / PA SIGNATURE			
D / C DATE	NURSE	TIME	RPH

1

PATIENT LAST NAME		FIRST NAME	
ID #		LOCATION	
DRUG		NEW	
INDICATION			
DOSE	ROUTE	RENEW	
FREQUENCY	DURATION	CHANGE	
DATE	TIME		
MD / PA SIGNATURE			
D / C DATE	NURSE	TIME	RPH

5

PATIENT LAST NAME		FIRST NAME	
ID #		LOCATION	
DRUG		NEW	
INDICATION			
DOSE	ROUTE	RENEW	
FREQUENCY	DURATION	CHANGE	
DATE	TIME		
MD / PA SIGNATURE			
D / C DATE	NURSE	TIME	RPH

2

PATIENT LAST NAME		FIRST NAME	
ID #		LOCATION	
DRUG		NEW	
INDICATION			
DOSE	ROUTE	RENEW	
FREQUENCY	DURATION	CHANGE	
DATE	TIME		
MD / PA SIGNATURE			
D / C DATE	NURSE	TIME	RPH

6

PATIENT LAST NAME		FIRST NAME	
ID #		LOCATION	
DRUG		NEW	
INDICATION			
DOSE	ROUTE	RENEW	
FREQUENCY	DURATION	CHANGE	
DATE	TIME		
MD / PA SIGNATURE			
D / C DATE	NURSE	TIME	RPH

3

PATIENT LAST NAME		FIRST NAME	
ID #		LOCATION	
DRUG		NEW	
INDICATION			
DOSE	ROUTE	RENEW	
FREQUENCY	DURATION	CHANGE	
DATE	TIME		
MD / PA SIGNATURE			
D / C DATE	NURSE	TIME	RPH

NYC 000106

NEW YORK CITY DEPARTMENT OF HEALTH  
AND MENTAL HYGIENE

CHS FORM A

## MEDICATION ORDER SHEET

USE BALL POINT PEN AND PRESS FIRMLY

ALLERGIES \_\_\_\_\_

4

PATIENT LAST NAME <i>Royce</i>		FIRST NAME <i>John</i>	
ID # <i>311600008</i>		LOCATION <i>Room 20</i>	
DRUG <i>Oxycodone</i>		NEW	
INDICATION <i>Pain management</i>			
DOSE <i>20mg</i>	ROUTE <i>PO</i>	RENEW	
FREQUENCY <i>Q 4 hours</i>	DURATION <i>1 Day</i>	CHANGE	
DATE <i>4/11/08</i>	TIME		
MD / PA SIGNATURE <i>[Signature]</i>			
D/C DATE	NURSE <i>[Signature]</i>	TIME	RPH

1

PATIENT LAST NAME <i>Royce</i>		FIRST NAME <i>John</i>	
ID # <i>311600008</i>		LOCATION <i>Room 20</i>	
DRUG <i>Oxycodone</i>		NEW	
INDICATION <i>Pain management</i>			
DOSE <i>20mg</i>	ROUTE <i>PO</i>	RENEW	
FREQUENCY <i>Q 4 hours</i>	DURATION <i>1 Day</i>	CHANGE	
DATE <i>4/11/08</i>	TIME		
MD / PA SIGNATURE <i>[Signature]</i>			
D/C DATE	NURSE <i>[Signature]</i>	TIME	RPH

5

PATIENT LAST NAME <i>Royce</i>		FIRST NAME <i>John</i>	
ID # <i>311600008</i>		LOCATION <i>Room 20</i>	
DRUG <i>Oxycodone</i>		NEW	
INDICATION <i>Pain management</i>			
DOSE <i>20mg</i>	ROUTE <i>PO</i>	RENEW	
FREQUENCY <i>Q 4 hours</i>	DURATION <i>1 Day</i>	CHANGE	
DATE <i>4/11/08</i>	TIME		
MD / PA SIGNATURE <i>[Signature]</i>			
D/C DATE	NURSE <i>[Signature]</i>	TIME	RPH

2

PATIENT LAST NAME <i>Royce</i>		FIRST NAME <i>John</i>	
ID # <i>311600008</i>		LOCATION <i>Room 20</i>	
DRUG <i>Oxycodone</i>		NEW	
INDICATION <i>Pain management</i>			
DOSE <i>20mg</i>	ROUTE <i>PO</i>	RENEW	
FREQUENCY <i>Q 4 hours</i>	DURATION <i>1 Day</i>	CHANGE	
DATE <i>4/11/08</i>	TIME		
MD / PA SIGNATURE <i>[Signature]</i>			
D/C DATE	NURSE <i>[Signature]</i>	TIME	RPH

6

PATIENT LAST NAME <i>Royce</i>		FIRST NAME <i>John</i>	
ID # <i>311600008</i>		LOCATION <i>Room 20</i>	
DRUG <i>Oxycodone</i>		NEW	
INDICATION <i>Pain management</i>			
DOSE <i>20mg</i>	ROUTE <i>PO</i>	RENEW	
FREQUENCY <i>Q 4 hours</i>	DURATION <i>1 Day</i>	CHANGE	
DATE <i>4/11/08</i>	TIME		
MD / PA SIGNATURE <i>[Signature]</i>			
D/C DATE	NURSE <i>[Signature]</i>	TIME	RPH

3

PATIENT LAST NAME <i>Royce</i>		FIRST NAME <i>John</i>	
ID # <i>311600008</i>		LOCATION <i>Room 20</i>	
DRUG <i>Oxycodone</i>		NEW	
INDICATION <i>Pain management</i>			
DOSE <i>20mg</i>	ROUTE <i>PO</i>	RENEW	
FREQUENCY <i>Q 4 hours</i>	DURATION <i>1 Day</i>	CHANGE	
DATE <i>4/11/08</i>	TIME		
MD / PA SIGNATURE <i>[Signature]</i>			
D/C DATE	NURSE <i>[Signature]</i>	TIME	RPH

NYC 000107

## CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH  
AND MENTAL HYGIENE

Leave blank for hospital use

Patients' Name \_\_\_\_\_ DOB \_\_\_\_\_

FROM \_\_\_\_\_  
Correctional institution / Inmate no.

Referred to \_\_\_\_\_ Ward / Clinic

Hospital \_\_\_\_\_ / Clinic no.

Chief complaint or findings:

**Diagnosis, treatment and medications by C.H.S.:**

Other pertinent physical, psychiatric, and historical findings,  
including lab values and x-ray findings:

Request:

Date \_\_\_\_\_ Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_ Approved \_\_\_\_\_

Consultation, findings and recommendations:

ate \_\_\_\_\_ Physician \_\_\_\_\_

NYC 000108

NYC HEALTH AND HOSPITAL CORPORATION  
CORRECTIONAL HEALTH SERVICES

DOCTORS ORDERS LIST

Reyes Jason

3490602628

1/13/83

NAME _____		ROOM NO. _____	
DATE	BY WHOM	BOOK & CASE # _____ NYSIS # _____	DATE
ORDERED		D.O.B. _____ ADMISSION TO CDU: _____	BY WHOM
		SPRUNG # _____ CELL # _____	DISCONTINUED
1/18/06	K	DIAGNOSIS: Reflex sympathetic dystrophy	
NIC		CONDITION: satisfactory	
De		VITAL SIGNS: Q11 ft	
		ACTIVITY: as tolerated	
		ALLERGY: Fentanyl	
		RESPIRATORY ISOLATION:	
		DIET: Regular	
		LABORATORY/DIAGNOSTIC TESTS: (PLEASE CHECK (✓))	
		___ CBC WITH DIFFERENTIAL	
		___ RPR / MHA - TP	
		___ SMA - 20	
		___ URINALYSIS	
		___ CHEST X-RAY: PA AND LATERAL VIEWS	
		ADDITIONAL TESTS: CHECK ONLY IF INDICATED:	
		___ PREGNANCY TEST (URINE)	
		___ HEPATITIS REFLEX PANEL	
		___ ESR	
		___ LYMPHOCYTE EVALUATION (T-CELLS PROFILE)	
		___ G - 6 - PD	
		___ SPUTUM GRAM STAIN AND C/S	
		___ 12 - LEAD ELECTROCARDIOGRAM (EKG)	
		___ OTHERS: PLEASE SPECIFY	
		SPUTUM INDUCTION FOR AFB SMEARS, CULTURE AND	
		SENSITIVITY ONCE A DAY FOR 3 DAYS	
		TEST FOR VISUAL ACUITY WITH SNELLEN'S CHART	
		TEST FOR COLOR VISION WITH ISHIHARA PLATES	

NYC 000109

PRINT NAME	
SIGNATURE	

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## DOCTORS ORDERS

Name Nyes Lash

Case No. 349-06-026

Ward \_\_\_\_\_

[illegible]

ATTN: NIC  
118 546.1154  
Dept Dorm 2-A.  
Dr Warden

RE: Jason Reyes  
3490662628

Medical Info:



## Neuroscience Associates of New York

399 Morgan Street, Staten Island, NY 10314 • 718/448-3210 • Fax 718/815-1320

### Neurology

Stephen A. Kirsch, MD, FAAN, FACP

William A. Schwab, MD

Audrey L. Roberts, MD

### Pain Management

Germeline N. Rowe, MD, FIAA, FPMR

Alan D. Bruck, DO

### Neurological Surgery

Edwin M. Chang, MD, FACS

John S. Shou, MD, FACS

Anthony J.G. Acosta, MD

### Emeritus

Harvey H. Leshmmer, MD, FACS

### Neuropsychology

Debra L. Wase, PhD

March 20, 2006

Re: Jayson Reyes

To Whom It May Concern:

Mr. Reyes has been a patient in our pain management practice since June of 2003. He is being treated medically for RSD or reflex sympathetic dystrophy also known as complex regional pain syndrome. RSD is a chronic neurological disease caused by a disturbance in the sympathetic nervous system. RSD is characterized by symptoms of severe pain and increased sensitivity to the area of pain associated also with swelling, color and temperature changes, circulatory changes as well as impairment in motor function or reduced range of motion.

For the patient's pain symptoms, he has been previously treated with a regimen of Oxycodone, 30 milligrams, every 12 hours, Cymbalta, 60 milligrams a day, and Lidoderm patches, 12 hours on and 12 hours off as well as Provigil, 200 milligrams a day.

If you have any further questions, please feel free to contact us in our office at 718-448-3210 ext. 2287.

Sincerely yours,

Naomi Alcock, P.A.

Germeline N. Rowe, M.D.

NA:aw

DocID: 158777167m ID: 1715, 18

2020 4th Avenue Brooklyn, NY 11209 • 718/238-0878  
A Division of HEALTHCARE ASSOCIATES • Medicine, PC

Page 1 of 1

NYC 000113



# HEALTHCARE ASSOCIATES in Medicine, PC

1099 Huguenot Street, Staten Island, NY 10314 • Phone: (718) 442-3210 • Fax: (718) 442-9085

FAX TRANSMISSION

DATE 2/13/06  
TO: Rosario 398-8995

COMPANY:

FAX

RE:

Number of p

MESSAGE



## Neuroscience Associates of New York

A Division of HEALTHCARE ASSOCIATES in Medicine  
1099 Huguenot Street, Staten Island, NY 10314 • 718/442-3210  
6030 4th Avenue, Brooklyn, NY 11209 • 718/386-0878

Neurology  
Stephen A. Wick, MD, FAAN, FACP  
James A. Schwartzberg, MD  
Anthony J. Nigam, MD  
Pain Management  
Bernard H. Stein, MD, FAAN, FACP  
Bernard Stein, MD

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Anthony J. Nigam, MD  
Pain Management  
Bernard H. Stein, MD, FAAN, FACP  
Bernard Stein, MD

Re: Reyes, Jayson on 2/13/06

To Whom It May Concern:

Please be advised that the above named patient is under my care for chronic foot pain to reflex sympathetic dystrophy (RSD).  
At the present time the patient:  
\_\_\_\_\_ may return to work full day  
\_\_\_\_\_ may return to work with the following limitations:  
\_\_\_\_\_

This fax may be used after the recipient, you information is

This fax may be used after the recipient, you information is immediately

It is treated medically for his pain symptoms with a regimen of Oxycodone 20mg every 12 hours, Amitriptyline 10mg/day, and Lidocaine patches 12 on, 12h off. He also uses Provigil 300mg/day. If you have any further questions, please contact me. Sincerely, Dr. Paul H. D.

NIC D2A

# **TEMPORARY PERMIT FOR CANES/MEDICAL ITEMS**

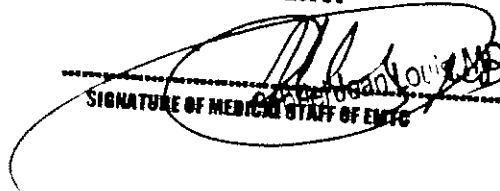
**TO EMTC- DEPARTMENT OF CORRECTIONS  
OFFICER IN CHARGE OF HOUSING AREA—**

DATE ISSUED 4/13/06

DATE EXPIRED INDEFINITE

INMATE REYES, JASON 3490602628  
NAME BOOK-N CASE NUMBER

**DUE TO MEDICAL REASONS HAS BEEN AUTHORIZED THE USE OF CRUTCHES  
BY RECOMMENDATION OF THE MEDICAL DEPARTMENT.**

  
SIGNATURE OF MEDICAL STAFF OF EMTC

INTER-HOSPITAL TRANSFER RECORD

From (Sending Hospital):

Bellows

To (Receiving Hospital):

Rivers NLC - Room 2B

Date: 4/17/06

Clinical Service:

Medicine

Patient's Name (Last)

Reyes

(First)

Jayson

Sex

M

Age

23

Birthdate

1/13/83

Medical Record #

3086604

Address

Borough

Zip

Apt. #

Telephone #

Next of Kin (Name)

Relationship

Telephone #

Transfer Notification

☐ YES ☐ NO

Name/Title of Person Contacted at Receiving Hospital

Dr. Ihim Ida Baslin

Telephone #

Diagnosis and Remarks:

Reflex sympathetic dystrophy

Past Medical History (including allergies, medications taken):

ESD 2/2 ankle trauma

Physical Findings and Treatment (including medications, IV fluids, and blood administered, lab and X-ray results, procedures done)

Oxycontin SR 10 mg q12 (titrate up PRN)

Noradren 300 mg BID

Lidoderm patch (or ointment)

Cymbalta 40 mg QD

Proxigal 200 mg qAM  
It would benefit from wheel chair

Special Equipment Transferred:

☐ X-Rays to Accompany Patient

☐ Laboratory Reports Attached

☐ Copy of E.R. Chart

Reason for Transfer:

☐ HHC Bed Unavailable

☐ Services Not Available

☐ Patient Request

☐ Other:

Patient's Condition at Transfer:

☐ Critical

☐ Serious

☐ Fair

☐ Good

Approved - Physician in Charge (Sending Hospital)

Name Print: Jean SCHWARZ

Title: PG&2

Signature:

MD Telephone # 917-401-1403

Approved Hospital Administrator

Name Print:

Signature:

Time:

Emergency Medical Service Notified Time:

AM/PM

Operator:

Time Ambulance Arrived at E.R.:

AM/PM

Time Patient Transferred:

AM/PM

Receiving Physician

Name Print:

Signature:

MD

Time:

Name of Accompanying Staff Member in Ambulance

☐ MD

☐ RN

Patients Valuables:

☐ Sent with Patient

☐ Given to Family

☐ Retained at Hospital

Patient's Clothing:

☐ Destroyed

☐ Discarded

☐ Given to Family

☐ Retained at Hospital

Staff Signature:

Family Signature:

Family Signature:

General Comments/Mental Status Evaluation:

NYC 000116

# CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH  
AND MENTAL HYGIENE

Leave blank for hospital use

Patients' Name _____		DOB _____
FROM _____	Correctional institution _____	Inmate no. _____
Referred to _____	Ward / Clinic _____	
Hospital _____	/ Clinic no. _____	

Chief complaint or findings:

**Diagnosis, treatment and medications by C.H.S.:**

Other pertinent physical, psychiatric, and historical findings,  
including lab values and x-ray findings:

(1)

Request:

Date \_\_\_\_\_ Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_ Approved \_\_\_\_\_

Consultation, findings and recommendations:

ite \_\_\_\_\_ Physician \_\_\_\_\_

# CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH  
AND MENTAL HYGIENE

Leave blank for hospital use

Patients' Name \_\_\_\_\_ DOB \_\_\_\_\_

FROM \_\_\_\_\_  
Correctional institution / Inmate no.

Referred to \_\_\_\_\_ Ward / Clinic

Hospital \_\_\_\_\_ / Clinic no.

Chief complaint or findings:

3

**Diagnosis, treatment and medications by C.H.S.:**

Other pertinent physical, psychiatric, and historical findings,  
including lab values and x-ray findings:

Request:

Date \_\_\_\_\_ Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_ Approved \_\_\_\_\_

Consultation, findings and recommendations:

to \_\_\_\_\_ Physician \_\_\_\_\_

Printed: Apr 17, 2006 01:15 pm  
 Bellevue Hospital Center  
 462 First Avenue  
 New York, NY 10016

Reyes, Jayson 3086604-2 EP?II  
 19S S46SA1  
 DOB: Jan 13, 1983 Age: 23Y Sex: male  
 Admitted: Apr 15, 2006 MR# 3086604  
 Attndg Physician: Bails, Douglas, MD  
 Service: General Medicine

Apr 17, 2006 01:14 pm: Discharge Summary

Disch Date : Mon, 17 Apr 2006  
 Reason for Admission : Left foot pain  
 Findings/Course :

Pt is a 23 yo DOC prisoner with h/o reflex sympathetic dystrophy secondary to forklift vs left ankle resulting in severe sprain at Home Depot who presents with inability to walk and worsening left ankle pain ever since being arrested when his outpatient pain regimen was discontinued. He had previously been on Oxycontin SR 20 q12, Cymbalta 60 qd, Lidoderm patch, Provigil 200 mg qd. All of these meds were discontinued when pt was arrested. Pt was evaluated by Neurology in ER who recommended Percocet, Neurontin and Lidocaine ointment.

Pt reported some improvement in his pain symptoms. Ankle film was negative. He was not able to ambulated however.

Pt stable for discharge. Should receive Oxycontin SR 10 q12 and titrate up PRN, Neurontin 300 TID, Lidoderm patch or ointment if patch not available. Would consider adding Cymbalta and or Provigil if symptoms continue. Would also recommend pt receiving a wheelchair.

Disch Prescriptions : Oxycontin SR 10 q12, Neurontin 300 tid,  
 Lidoderm patch  
 Disposition : transferred to RIKERS  
 Problem # 1 : Reflex Sympathetic Dystrophy, Lower Limbs

Electronically signed by Schwarz, Scott, MD

Apr 17, 2006

NYC 000119

Printed Apr 17, 2006 1:15 pm by Schwarz, Scott

p. 1 of 1

# Bellevue Hospital Center Discharge Instruction Sheet

**IMPORTANT:** Please bring this form to your first appointment with your doctor.

**IMPORTANTE:** Por favor, traiga ésto documento a la primera visita con su médico.

**重要通知:** 第一次看醫生時請您帶上這張表格。

## MD to Complete

Diagnoses:

*Reflex Sympathetic Dystrophy*

Surgery/Special Procedures:

Home Care Ordered: ☐ Not Required ☐ Yes

Activity Limitations: ☐ None ☒ Yes/Specify:

Give DVT Discharge Instructions ☐

*As tolerated*

Allergies: ☐ No Known Allergy ☒ Yes/Specify:

Diet Ordered: ☒ Regular ☐ Other/Specify:

Your Medications Are:

☐ No Medication Ordered

Name

Dose

How Often

Reason for Taking

*Hydrocodone 5/2 12 mg q 2nd 1st 40 mg p 1st 40 mg*

*gabapentin 300 mg tid*

*gabapentin patch 100 mg*

*gabapentin 100 mg bid*

Additional Instructions (e.g., labs, tests, non-drug pain management, etc.):

Your Follow-up Care: ☐ To Be Seen in Bellevue Clinic: see below

☐ Referred to Bellevue Stop Smoking Program at 5 South 51, (212) 562-4748.

MD Requested Appointment			
Clinic	Date Requested	MD (if known) PRINT	SMS Appt Given
(X) NEW			Date Time
( ) REV	_____ days or _____ weeks	<i>Dr. [Signature]</i>	
( ) NEW			
( ) REV	_____ days or _____ weeks		
( ) NEW			
( ) REV	_____ days or _____ weeks		

☐ Patient Requests Appointment with Private MD.

☐ Refer to Non-Bellevue Managed Care Provider.

MD Name (Print):

MD Signature:

Date:

ID Number:

**Hospital Transfer Form**

Please use ball point pen and print legibly.

Referring DOC Facility: \_\_\_\_\_  
 Name of referring MD \_\_\_\_\_  
 (Please Print)  
 Hospital Run: ☐ EMS ☐ DOC: ☒ 3 hr. MD Phone # \_\_\_\_\_  
 Date: 4/1/08 Time: \_\_\_\_\_ AM/PM  
 Referred to: ☐ KCHC ☐ Elmhurst ☒ Bellevue  
☐ Other: \_\_\_\_\_  
 Patient Name: \_\_\_\_\_  
 B&C #: \_\_\_\_\_ (Please Print) DOB: \_\_\_\_\_  
 Contact Urgicare if you have questions: **Beeper# 917-949-1234**  
**Phone# 718-546-4333**

COMPLAINT: \_\_\_\_\_ PE \_\_\_\_\_  
 PMH: \_\_\_\_\_  
 Studies/Labs \_\_\_\_\_  
 MEDS: \_\_\_\_\_  
 Tx @ RI \_\_\_\_\_  
 Allergies: \_\_\_\_\_

Significant ED findings/studies: \_\_\_\_\_  
 Discharge Dx: \_\_\_\_\_  
 Recommended FU: \_\_\_\_\_

**Fax completed form to Urgicare Center @ time of discharge - 718-546-4382**

Physician Name (print) \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Phone # \_\_\_\_\_

CONTACT URGICARE IF YOU HAVE QUESTIONS / INFORMATION.

FOR BOROUGH HOUSES CONTACT REFERRING PRACTITIONER (ABOVE).

BEEPER #: 917-949-1234  
 PHONE #: 718-546-4333



# HEALTHCARE ASSOCIATES in Medicine, PC

1099 Surgoe Street, Staten Island, NY 10314 • Phone (718) 448-7210 • Fax (718) 442-8043

## FAX TRANSMISSION

DATE: 4/11/06

TO: Roana

COMPANY: \_\_\_\_\_

FAX: 398-8995

RE: \_\_\_\_\_

FROM: Baron

DEPT: \_\_\_\_\_

FAX: 718-447-7192

TEL: 718-448-8210 X

**PHYSICIAN**  
Stephen A. Fuchs, MD, MAC, DCP  
Barry L. Shapiro, MD

**PHYSICIAN ASSISTANT**  
James R. Johnson, MD  
Lynn M. Bland, MD

**PHYSICIAN**  
Mark E. Young, MD, MAC  
John S. Bland, MD  
Anthony L. Bland, MD  
Harvey R. Lippman, MD, MAC  
Barry L. Shapiro, MD

**PHYSICIAN**  
Stephen J. Fuchs, MD, MAC  
Joseph A. Shapiro, MD, MAC  
Albert R. Shapiro, Jr., MD  
John R. Bland, MD  
David A. Shapiro, MD  
Lynn M. Bland, MD, MAC

Number of pages including cover

**OFFICIAL NEW YORK STATE PRESCRIPTION**

DATE: 4/11/06

PHYSICIAN: Baron

PATIENT: Roana

DRUG: Ex-100

DOSE: 250mg

ROUTE: PO

PRESCRIPTION: 100 tablets

REFILL: 10

PHARMACY: Roana

PHYSICIAN SIGNATURE: [Signature]

PHYSICIAN ID: 100

Number of pages including cover

**OFFICIAL NEW YORK STATE PRESCRIPTION**

DATE: 4/11/06

PHYSICIAN: Baron

PATIENT: Roana

DRUG: Ex-100

DOSE: 250mg

ROUTE: PO

PRESCRIPTION: 100 tablets

REFILL: 10

PHARMACY: Roana

PHYSICIAN SIGNATURE: [Signature]

PHYSICIAN ID: 100

9220 4th Avenue  
Brooklyn, NY 11209

3311 Mylem Boulevard  
Staten Island, NY 10314

38 Columbia Avenue  
Staten Island, NY 10314

1460 Victory Boulevard  
Staten Island, NY 10314

82

(716) 830-9727  
NY 10005

2175 AVE  
2175 AVE  
2175 AVE

150

[illegible]

5813

\*\*\*\*\* THIS REPORT CONTAINS PATIENT HEALTH INFORMATION WHICH IS LEGALLY PROTECTED UNDER HIPAA LEGISLATION  
\*\*\*\*\* THIS INFORMATION MUST BE USED AND STORED IN ACCORDANCE WITH THE AID PRIVACY POLICY \*\*\*\*\*